OMB No. 0920-0666
Exp. Date: xx-xx-20xx

Facility Contact Information

*Tracking # : _____

Facility Information:_

*Facility Name: _____

*Main Telephone Number: ( ) _____-_____

*Mailing Address:_____

_____

_____

*City: _____ *County: _____ *State: _____ *ZIP: _____-_____

For each identifier listed below, enter the # / code or check Not Applicable if your facility does not have that identifier:

*American Hospital Association ID # : _____ Not Applicable

*CMS Provider # : _____ Not Applicable

*VA Station Code: _____ Not Applicable

If none of the above identifiers is applicable, enter CDC-provided Enrollment # : _____

*__Facility Type (indicate one from list):__

_____

*__NHSN Components:__ Indicate which component(s) the Facility will use initially use (components may be added at any time after enrollment)

Patient Safety Component

Healthcare Personnel Safety Component

NHSN Facility Administrator:

*Name:

_____

Title: _____

Mailing Address: (if different from facility)

_____

_____

_____

City: _____ State: _____ ZIP: _____

*Telephone Number: ( ) _____-_____ Extension: _____

FAX Number: ( ) _____-_____

Pager Number: ( ) _____-_____

*Email: _____ *A valid email account is required.*

*User Name: _____

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

NHSN Patient Safety Primary Contact Person (*if different from Facility Administrator*):
Name: _____
Title: _____
Mailing Address: (if different from facility)
_____

_____

_____
City: _____ State: _____ ZIP: _____-_____
Telephone Number: ( ) _____-_____ Extension: _____
FAX Number: ( ) _____-_____
Pager Number: ( ) _____-_____
Email: _____ *A valid email account is required.*

NHSN Healthcare Personnel Safety Primary Contact Person (*if different from Facility Administrator*):
Name: _____
Title: _____
Mailing Address: (if different from facility)
_____

_____

_____
City: _____ State: _____ ZIP: _____-_____
Telephone Number: ( ) _____-_____ Extension: _____
FAX Number: ( ) _____-_____
Pager Number: ( ) _____-_____
Email: _____ *A valid email account is required for enrollment.*

Microbiology Laboratory Director/Supervisor *(if different from Facility Administrator):*
Name: _____
Title: _____
Mailing Address: (if different from facility)
_____
_____
_____
City: _____ State: _____ ZIP: _____-_____
Telephone Number: ( ) _____-_____ Extension: _____
FAX Number: ( ) _____-_____
Pager Number: ( ) _____-_____
Email: _____ *A valid email account is required for enrollment.*